Health Complaints Commissioner Tasmania

Annual Report 2017/18

Health Complaints Commissioner

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Letter to Parliament

To:

The Honourable President of the Legislative Council

and

The Speaker of the House of Assembly

Pursuant to section 12 of the *Health Complaints Act 1995*, I present to the Parliament the annual report of the Health Complaints Commissioner for 2017-18.

Yours sincerely

Richard Connock
HEALTH COMPLAINTS COMMISSIONER

26 November 2018

About this Report

This report describes the functions and operations of the Health Complaints Commissioner Tasmania for the year ending 30 June 2018.

It is available in print or electronic viewing format to optimise accessibility and ease of navigation. It can also be made available in alternative formats to meet the needs of people with a disability. Requests should be directed to the Executive Officer at 1800 001 170 or Health.Complaints@ombudsman.tas.gov.au.

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From the Health Complaints Commissioner

This annual report is made pursuant to section 12 of the *Health Complaints Act 1995* (the Act), and details the work of my Office during 2017-18.

Introduction

With increased complaint numbers and decreased staffing levels 2017/18 has been another challenging year. This situation has resulted in more cases being opened than closed and an increased number of cases open and being carried forward at the start of the 2018/19 reporting year.

Notwithstanding this, a number of significant outcomes were achieved and improvements in the delivery of health services implemented over the reporting year because of the assessment, conciliation and investigation of complaints received by this Office. Case summaries highlighting some of these improvements appear at the end of this report. Other examples will be published on our website.

Enquiry and Complaint Management

A large proportion of matters brought to our attention are resolved informally by members of my staff in the enquiry stage. After a spike in enquiry numbers last year the number of matters closed in enquiry decreased by 24% this year. There was, however, an 8% increase in the number of formal complaints (348 to 377). A significant proportion of the complaints received are complex with multiple parties needing to be consulted and managed.

Staffing

I have referred to the low staffing levels in the Health Complaints' team in previous reports. These had reached their lowest point in August 2015 (2.2 FTEs) following the retirement of a part time conciliator, the finalisation of a fixed term contract and the retirement of an Intake and Assessment Officer.

Steps were taken to address this situation in the 2015/16 year but unfortunately, absences due to illness and injury throughout 2016/17, and the retirement and transfer of staff to other agencies in 2017/18 has resulted in significant periods when there have been only two members of staff working in the health jurisdiction.

From a staff of 4.2 FTEs we lost three officers representing 2.4 FTEs. At the time of writing this report, the health team has been restored to 4.2 FTE.

Low staff levels not only had an adverse impact on the time taken to resolve complaints but also, with a necessary focus on complaint resolution, they have resulted in an inability to perform other functions prescribed under the Act. These include things such as: education on health rights; building complaint resolution capacity in providers; auditing improvements to health services; and conducting own motion investigations.

Delays

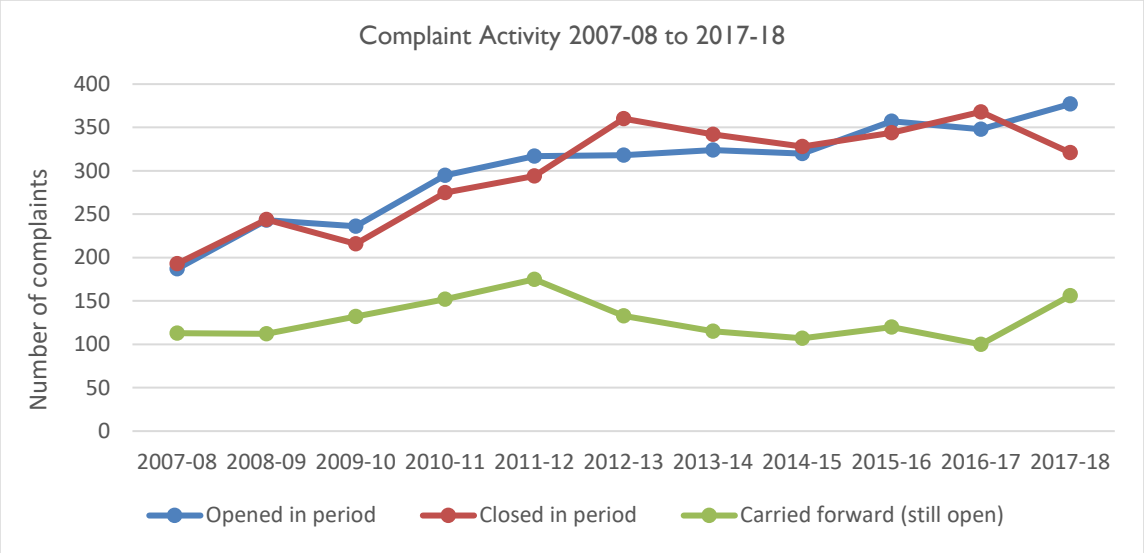
Delays continue and have been exacerbated over the last two to three years by the significant time it can take to obtain responses from the Tasmanian Health Service (THS), following the restructuring of its patient safety division. We have also experienced significant delays in obtaining responses from the Australian Health Practitioner Regulation Agency (AHPRA) with whom we are required to consult in respect of all complaints received about registered practitioners.

These delays result in valuable time, effort and resources being spent by members of my staff following up and re-familiarising themselves with the issues, as well as loss of momentum. Delays such as these have a seriously adverse impact on the parties to the complaint, not only the consumers and their families who are seeking answers but also the practitioners whose performance is being questioned. They also place an additional burden on my staff who have to deal with parties aggrieved by the delays.

Ten Year Trend

A review of OHCC statistics over the past 10 years indicates that complaint numbers have almost doubled in that period. During the same period, staffing levels have dropped by one-third (six FTEs to four FTEs) with significant periods with even fewer staff. The number of cases carried forward at the end of each year bears a direct correlation to the staffing levels at the time.

Figure 1 - Complaint Activity 2007-08 to 2017-18

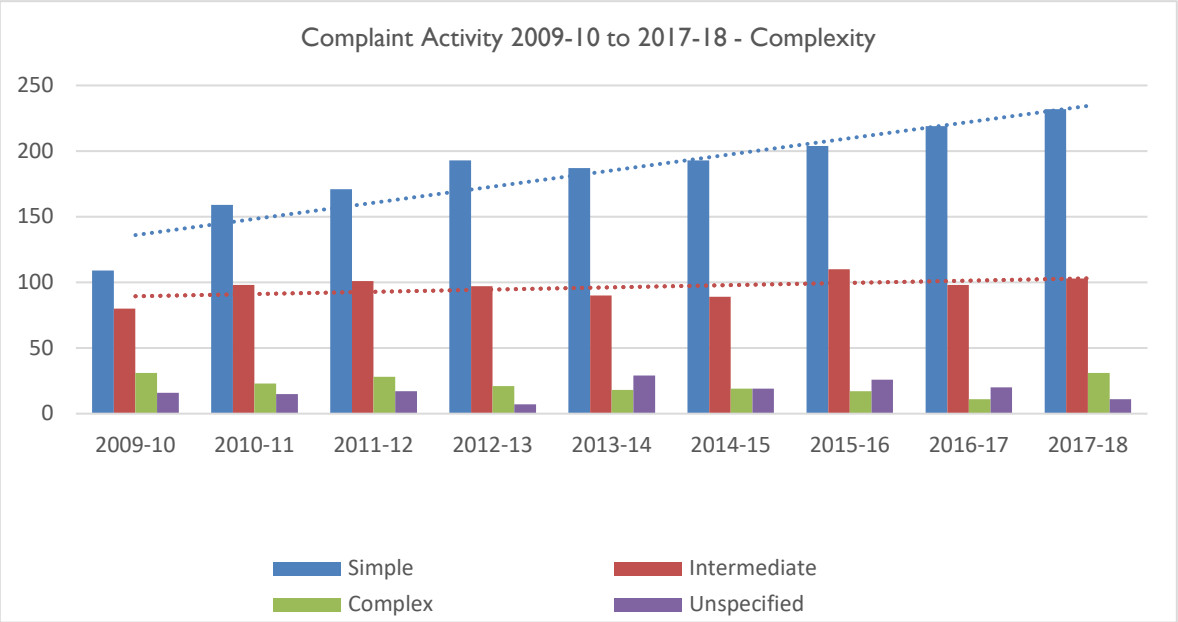


*This table does not include notifications received from registration boards

As the graph below shows, the main growth is in simple cases with the number of complex and intermediate cases remaining reasonably static. At times of low staff levels, with the need to deal with enquiries as they are received, and the legislative imperative to assess as many cases as quickly as possible, priority tends to be given to the more straightforward cases. The drawback is that a greater proportion of complex cases are carried forward than received.

This is particularly notable over the last three reporting years for reasons already stated.

Figure 2 - Complaint Activity 2009-10 to 2017-18 - Complexity



Code of Conduct for Health Care Workers

At a meeting of the Commonwealth Parliamentary Standing Committee on Health in June 2013, Australia's Health Ministers agreed in principle to the establishment of a National Code of Conduct for Unregistered Health Care Workers (the Code), such as naturopaths, social workers and counsellors.

It was agreed at the Council of Australian Governments (COAG) Health Council meeting in April 2015 that this would proceed. Each State and Territory is responsible for enacting new, or amending existing legislation to give effect to the Code, which will be administered by the Health Complaints Entities in each jurisdiction.

Implementation of the Code has been the subject of continuing discussion at Health Complaints Commissioners' meetings. A working group, including representatives from all States and Territories and the Victorian Health and Human Services Department, has convened for monthly teleconferences to co-ordinate the consistent implementation of the Code across jurisdictions. This involves developing a common framework for the collection and reporting of data and for annual performance reporting to the COAG Health Council. In addition, work is continuing on a national web site.

Members of my staff performed a great deal of work during the reporting year in relation to amendments to the Tasmanian Health Complaints Act and the National data base in readiness for the Code's introduction. We worked with the Department of Health and Human Services and the Office of the Parliamentary Draftsman reviewing and settling proposed amendments to the Act. We also consulted counterparts in other jurisdictions that already have codes, who have provided, and continue to provide, valuable advice and guidance.

At the time of writing, the amended Act has passed through Parliament but has not been proclaimed.

What exactly this change in the law will mean for the Office is not clear, but the work that will be involved will be different to what we presently do. The new work will carry a high degree of responsibility as the amended Act empowers my Office to make prohibition orders against unregistered practitioners. These result from a process more in the nature of a prosecution than an investigation and existing staff will require additional training before entering into that process.

It is not possible to say how many notifications we might receive but any will mean an added strain on resources that are already stretched. If a significant number are received, existing resources will not be sufficient to deal with them. There will also need to be extensive modifications to our case management system to accommodate workflows related to the administration of the Code.

I am concerned that without additional resources and funding, we will not be able to perform this new function adequately.

Conciliation

Only three matters were referred to conciliation this year and, despite a number of conciliation matters being carried forward from last year, only five were finalised. This was due mainly to low staffing levels and the inability to finalise assessments due to the delays in receiving information referred to above. We also experienced significant delays in the scheduling of meetings with public hospitals due to the lack of availability of necessary representatives.

Efficiencies

We continue to search for efficiencies. We are currently undertaking a review of our processes in an attempt to identify strategies that will increase our ability to undertake the important functions referred to above. We engaged an outside facilitator to help us with this review, but staff movements led to a hiatus. I am hopeful that we will resume the review in the next reporting year.

We continue to resolve a significant number of matters informally at the enquiry stage and to refer matters back to providers for an attempt at direct resolution with complainants.

We will also continue to work with our local AHPRA office to identify ways to expedite processes, and to meet with key stakeholders, particularly in the public hospital system, to explore the ways in which more timely responses can be delivered in both the assessment stage and when a matter has been referred to conciliation.

Conclusion

I would once again like to thank my Health Complaints' staff for the quality of their work, for their dedication and professionalism and for sustaining their remarkable levels of activity over what has been another very challenging year.

The Office of the Health Complaints Commissioner

The *Health Complaints Act 1995* established the Office of the Health Complaints Commissioner (OHCC) in 1997. The major functions of the Office are to:

- receive, assess and resolve complaints from health service users;
- assist health service providers in developing procedures to resolve complaints;
- encourage health service users to resolve complaints directly with health service providers; and
- identify and review issues arising out of complaints and suggest ways of improving health services.

The Commissioner is an independent statutory officer who does not represent the interests of, nor act as an advocate for, either party to a complaint. The functions of the Commissioner are performed independently, impartially and in the public interest. It is not the role of the Commissioner to attribute fault or blame, but to seek improvements in the delivery of health services in Tasmania and, where possible, resolve complaints between the parties through conciliation.

It has been the practice since the commencement of the Act for the appointments of Ombudsman and Health Complaints Commissioner to be held by the same person. The functions which go with these two separate appointments are delivered by the same Office, the Office of the Ombudsman and Health Complaints Commissioner.

Staff Profile

The staffing profile for the OHCC at the end of the reporting year was as follows:

Position	Male	Female	Total
Commissioner	0.2	0.0	0.2
Principal Officer (Band 8)	0.0	1.0	1.0
Senior Investigation Officer (Band 6)	0.0	1.2	1.2
Resolution Officer (Band 5)	0.0	1.0	1.0
Intake and Assessment Officer (Band 4)	0.0	0.0	vacant
TOTAL	**0.2**	**3.2**	**3.4**

2017-18 At A Glance

- A 24% decrease in enquiries received
- An 8% increase in complaints received
- A 20% increase in notifications received
- A 13% decrease in complaints closed
- 82% of complaints closed within 6 months
- 88% of complaints assessed within 90 days
- A 13% decrease in the number of matters closed in assessment
- A 62% decrease in cases referred to conciliation
- 49 AHPRA notifications received
- 65 complaints recorded as resolved in assessment
- One investigation completed

Complaint and Enquiry Activity

Enquiries

A large number of enquiries are received each year, by telephone, email and in person. Enquiries are dealt with as they are received and represent a substantial workload.

OHCC staff play a significant role in identifying the issues a potential complainant is concerned about and encouraging them to discuss their concerns directly with the health service provider involved. They will often take steps to assist parties to resolve the issues at this point and, if the enquiry does not fall within the jurisdiction of the OHCC, to facilitate referrals to other agencies.

Table 1 shows the number of matters opened and closed as enquiries during the reporting year. Following an unusual spike in enquiry numbers last year (from 377 to 553) Table 1 indicates a decrease (from 553 to 423) to more normal historical levels.

Table 1 – Enquiry Activity

Enquiries	2016-17	2017-18	Variance
Enquiries received	553	423	-24%
Enquires closed	550	408	-26%
Enquires active	21	37	76%

Complaints

If a person has a grievance about a health service provider, and they have not been able to resolve their concerns directly with the provider or at the enquiry level, they are able to make a complaint.

The Act requires that a complaint be in writing. When a complaint is received, OHCC staff contact both parties to identify and discuss the issues and, in appropriate cases, attempt to resolve those issues as quickly as possible by way of early resolution. Where this is not possible the complaint proceeds to formal assessment.

Table 2 shows the number of complaints opened and closed during the reporting year. It also shows the number of matters carried forward at the beginning and end of the period. Table 2 indicates an 8% increase in the number of complaints received, a 13% decrease in the number of complaints closed and a 56% increase in the number of active complaints open at the end of the reporting year to be carried forward into next year.

Table 2 – Complaint Activity

Complaints	2016-17	2017-18	Variance
Complaints carried forward	120	100	-17%
Complaints received	348	377	8%
Complaints closed	368	321	-13%
Complaints active	100	156	56%

Notifications

The OHCC also receives notifications from AHPRA. In past annual reports, notifications initially made to AHPRA (in respect of matters that this Office & AHPRA are required to consult about under National Law) have been classified and reported on separately from complaints. In last year's report we indicated that complaints and notifications would be combined in future reporting. This has not yet occurred. The number of notifications set out in Table 3 below are therefore in addition to the number of complaints received.

Table 3 indicates a 20% increase in the number of notifications received from AHPRA this year compared with last year. The number of active matters at the end of the year, which will be carried forward into the next reporting year, more than doubled.

Table 3 - Notification Activity

Notifications from AHPRA	2016-17	2017-18	Variance
Notifications carried forward	26	16	-39%
Notifications received	41	49	20%
Notifications closed	51	30	-41%
Notifications Active at 30/6	16	35	118%

Who and What did People Complain About?

Consistent with previous reports the recurring issues raised in complaints relate to poor communication, inadequate care and treatment, and failure to prescribe medication.

Correctional Primary Health Services

As in previous years, the main source of complaints about prescribing came from prisoners in the Tasmanian Prison Service. There was, however, a 14% reduction in the number of complaints about Correctional Primary Health Services from141 to 120.

Inmates are able to call this Office directly on a secure line at no cost. The most common reason for inmates to call was because they were seeking access to the suboxone opioid replacement program, or seeking access to stronger pain relief. To that end, the main issue raised was failure to prescribe medication, but the next most common issues, and directly corresponding reason for complaint were 'refusal to treat' and 'inadequate treatment.'

Another common reason for complaints by inmates arises because they want access to a doctor and other treatment services such as dental, optometry, surgery and cosmetic surgery, in the same timeframe as they would gain access to those services in the community (same day or next day appointments).

Tasmanian Health Service

In line with previous years, public hospitals were the subject of the next highest number of complaints. There was a 47% increase in the number of complaints from 51to 75 as well as a 50% increase (six to nine) in the number of complaints received about mental health services. As in previous years, the main issues raised were treatment and communication. There was a notable increase this year in the number of complaints relating to delays or failure by public hospitals to respond to complaints made directly to them. The main issue in relation to mental health services was refusal to admit or treat.

Medical Clinics

There was a reduction in the number of complaints about medical clinics from 31 to 27. Recurring themes related to informed financial consent and billing practices.

Individual Providers

Most complaints received about individual providers related to medical practitioners. As noted in previous reports, this is attributable to there being more doctors than other individual health providers apart from nurses. Complaints about the latter, however, are mainly incorporated into complaints about hospitals. There was an increase in the number of complaints received about medical practitioners this year from 52 to 71.

How Were Complaints Resolved?

Table 4 - Reason for Closure of Complaints and Notifications

Reason closed	2016-17	2017-18
No further action following Assessment	329	290
Referred to board pursuant to MOU	15	24
Retained by board pursuant to MOU *	51	30
Conciliation completed	21	5
Investigation completed	3	2
Total	**419**	**351**

*These cases started as notifications to AHPRA

Assessment

The majority of complaints received are closed following assessment. This was the case with 290 complaints closed this year. In the language of the Act, complaints closed following assessment are recorded as having been 'dismissed', as opposed to being referred to investigation, conciliation, a registration board, or elsewhere. This terminology is unfortunate, as it fails to convey the extent of the work undertaken during the assessment phase and the significant outcomes achieved from the assessment process.

Assessment is the stage under the Act at which a determination needs to be made as to whether a complaint will be dismissed, referred to another entity, referred to conciliation or referred to investigation. In this stage, responses are sought from providers, medical records are reviewed, expert opinions sought, consultation occurs with AHPRA and attempts are made to resolve the complaint without the need for referral to formal investigation or conciliation.

The various reasons for closing a complaint in assessment are set out in Table 5. These reasons accord with the language of s25(5) of the Act, which stipulates the circumstances in which a complaint must be dismissed. Most of these relate to threshold issues, which result in a complaint being dismissed at an early stage in the assessment process. The remaining two reasons, which account for 79% of all complaints dismissed in assessment during the reporting year - and which are subject to the more protracted process described above - are that the complainant has been given a reasonable explanation about the incident that led to the complaint, or that the complaint has been resolved.

Referral to Registration Boards and Other Entities

The relationship between this Office and the national boards and AHPRA is governed by the *Health Practitioner Regulation National Law Act* (National Law). An MoU is in place between AHPRA and the various Health Complaints Entities to guide the interaction between those entities and AHPRA, particularly with respect to the operation of s150 of the National Law.

Table 4 indicates that in 2016-17 there were 54 cases either referred to or retained by a registration board pursuant to the MoU of which 24 were referrals from this Office. We consulted, however, in relation to an additional 19 matters that were not ultimately referred to a board. These additional consultations arose from complaints made about hospitals where a registered provider had been involved in the episode of care. As discussed elsewhere in this report, the consultation process between this Office and AHPRA has a significant impact on the time taken to assess or progress complex complaints.

Some complaints received require attention from agencies other than registration boards. For example, complaints against aged care facilities might be referred to the Aged Care Complaints Commissioner, and complaints relating to mental health facilities might be referred to the Mental Health Official Visitor Scheme established under the *Mental Health Act 1996* and now covered by the *Mental Health Act 2013*. Appropriate consultation occurs prior to referral. These matters are generally closed in the assessment stage because, unlike referrals to registration boards, they do not generally require further consideration by OHCC staff. There were five such cases this year.

Conciliation

Most complainants want to understand what happened, and why it happened, and are often seeking an apology, ongoing care and/or compensation. They also want to know what can be done to prevent what happened to them happening to someone else. Conciliation under Part 5 of the Act is confidential and privileged, and as such provides a safe forum where the parties can have open and honest discussions about these issues.

In previous years, conciliation has been used extensively and with great success in resolving complaints and as a vehicle for exploring and bringing about systemic change. Only three matters were referred to conciliation this year and only five were closed.

There are a number of reasons for the drop in these figures. These include; again, our low staffing levels; the restructuring of the Tasmanian Health Services (THS) Patient Safety Service, which resulted in delayed responses and a lack of staff available to deal with complaints and attend conciliations; and delays in the consultation process with AHPRA described above.

As noted earlier, steps are being taken at the time of writing to address all these issues and it is hoped that the conciliation function of this Office will become fully operational again in the coming year.

Outcomes from conciliation are set out in Table 7 in the appendix to this report. Of the five cases closed, one resulted in the payment of compensation, and four resulted in significant quality improvements, including changes in policy or procedure. In nearly all cases, the complainants' concerns were resolved by the provision of further information or an

explanation, in language they could understand, or simply by having those concerns acknowledged and receiving an apology.

An example of a matter dealt with in conciliation appears in the case study section at the end of this report and will be published on our website.

Investigations

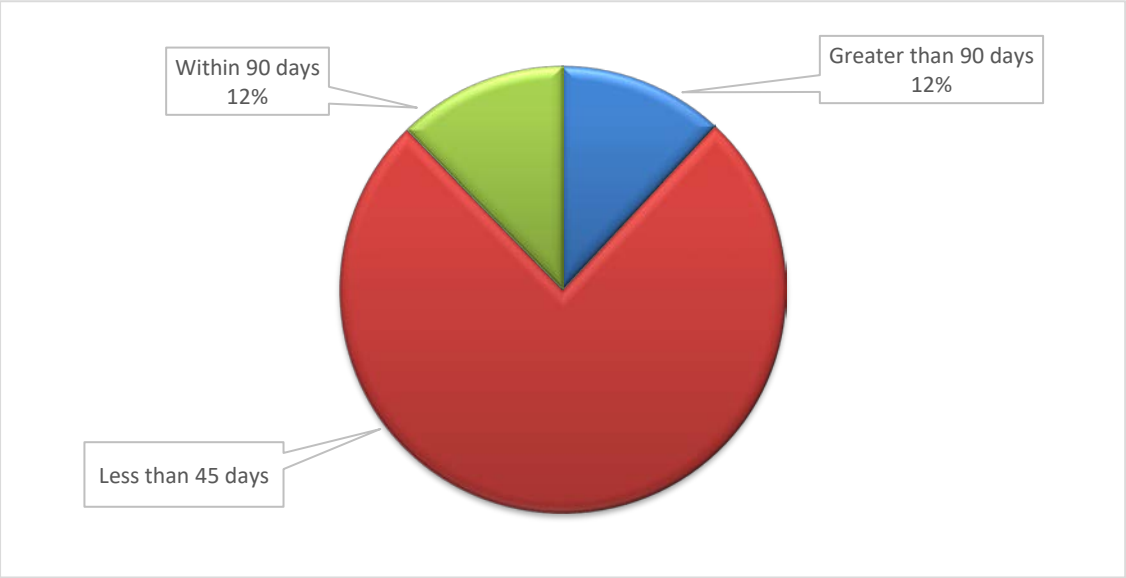
A decision was made some years ago that formal investigations would only be conducted into complaints which give rise to a matter of public interest, and that conciliation would be used more extensively. One of the reasons for this was that in many cases, by the time the matter is brought to our attention, the provider has already engaged in a root cause analysis, and this has led to the identification and implementation of systemic changes necessary to prevent a recurrence of the subject incident. These outcomes are then shared with the complainant at conciliation.

The matters referred to investigation have tended to be those that affect vulnerable groups. One matter was closed in investigation this reporting year. A summary of this case appears in the case summaries at the end of this report.

Time Taken to Assess and Finalise Complaints

Time taken to assess complaints

Figure 3 - Time taken to assess complaints



The Act requires that a complaint be assessed within 45 days. This can be extended to 90 days, and longer in some cases. There are a number of circumstances, described in past annual reports, and referred to earlier in this report, which have an impact on this Office's ability to meet these statutory periods, and which are beyond our control.

There were several instances in this reporting year of delays of more than six months in THS providing responses to complaints about public hospitals and other State funded services, and similar delays in receiving responses from AHPRA during the consultation process which occurs pursuant to National Law and the MoU.

These delays not only have a deleterious effect on the parties to the complaint but also stifle any momentum, and have an adverse impact on the management of the complaint by this Office. An amendment to the Act came into effect in October 2015, which permits the assessment period to be extended *if there is a delay in obtaining information requested by* [the Commissioner]. Unfortunately, although this amendment has the potential to reduce our reported assessment times it does not obviate the detrimental impact caused by the delays.

Having said that, in this reporting year 12% of cases were assessed outside the 90-day period compared with 19% last year.

Time taken to finalise complaints

Figure 4 – Time taken to finalise complaints

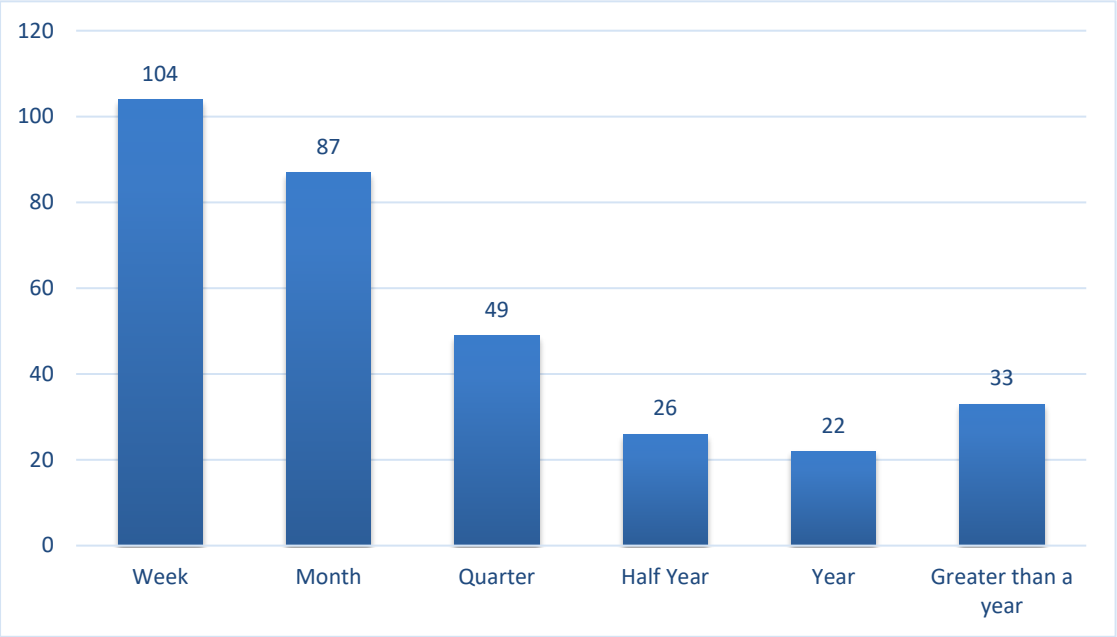


Figure 2 illustrates the time it takes to finalise the various types of complaints received. As previously noted, the less complex complaints are generally resolved within three months, and generally make up around 65% of all complaints received. The remaining 35% tend to be more complex.

The statistics for this year show an increase in the percentage of complaints taking more than 12 months to finalise. It was reported last year that of the 100 complaints carried forward at the end of the reporting year, 45 were more than 300 days old. The position is similar this year with 43 of the 150 matters carried forward being more than one year old and an additional 80 cases being more than six months old.

As reported above the major factors affecting the time within which complaints are finalised are the increased complexity of complaints, decreased staffing levels and delays and difficulty in receiving necessary advice and information from various sources.

Another factor in relation to complaints about registered practitioners, is the reluctance of those individuals to engage in conciliation, particularly involving claims for compensation, until finalisation of any action by the relevant registration board. This results in cases remaining open pending the outcome of those proceedings and a delay over which this Office, again, has no control.

Again as reported earlier, we are always looking at ways to make processes more efficient to make the best use of the resources at our disposal.

Case Summaries

The following case summaries have been de-identified to protect the identity and privacy of the parties, and demonstrate the variety of matters we deal with.

Cases Closed in Enquiry

Medication Reinstated

Mr A was in extreme pain when he visited our Office seeking help to resolve an issue regarding an apparent refusal to prescribe medication by his specialist physician. To date, Mr A had been prescribed a number of different medications, with only one being successful. The specialist involved, however, refused to continue to prescribe this medication and had not addressed Mr A's questions as to why he could no longer be prescribed the drug.

The OHCC contacted the clinic staff who advised that Mr A did not reach the 'responsivity threshold' for continuing the particular treatment. Although Mr A explained that his symptoms were considerably improved when taking this drug, there was no 'biomarker' for this alleged improvement. Following discussions with the treating physician, however, the drug was reinstated and the complainant was very pleased with the outcome.

Financial Consent and Possible Misrepresentation

An elderly complainant who resided in a rural area responded to an advertisement for a 'free hearing test' offered by an audiology service some 50 kilometres from her home. During the initial audiology consultation, she was told that she had hearing loss and that if she wanted to obtain treatment or information about her condition, or suitable hearing aids she would have to return for a second appointment, which would cost her $50.00.

Following this second hearing test, Mrs X was advised that she required specific hearing aids. As the devices were costly, ranging in price from $2,000.00 to $13,000.00, Mrs X wanted to be able to discuss the specifications of these aids with her son and her friends. She therefore requested a written quotation and information about the specifications of the aids. The audiologist refused to provide her with either. Mrs X felt 'she had been tricked' by the audiology service and the cost of the appointment and the distance required to travel for the second appointment represented a significant financial liability for her. She was distressed and confused by the experience and contacted the OHCC for help.

The OHCC contacted the provider and was advised that the clinic's normal procedure is to explain to the client prior to attending that they will normally need two appointments if they have hearing loss and require aids. The provider was adamant that Mrs X should have been provided with quotations for suitable aids and their product numbers to allow her to discuss the matter with her family members after the consultation. The outcome was favourable for Mrs X in that the service provider agreed to waive the fee in this instance and provided an apology to Mrs X for the inadequacy of the service.

Improvements to Billing Practices

When Miss J's regular physician retired from a specialist clinic, she was allocated a new physician. She was charged a high fee for her first consultation with the new physician without explanation. She believed the fee to be unreasonable as she was a long term patient of the clinic and all her medical records were on file.

Explanation was sought by the OHCC from the practice manager (PM) of the clinic about the issues raised, in particular a failure to advise existing patients of the reasons for the fee increase. The PM agreed that existing patients were not being advised appropriately of the reasons for the large fees being charged to them when they are to be seen by an alternative physician in the practice. The PM agreed to provide an explanation for existing patients as to why they are being treated as new patients to the clinic. Mrs J was pleased about the change to be implemented in the practice and satisfied with the explanation for the high initial consultation fee.

Fee for second driving assessment test

His medium-rigid drivers licence was due for renewal so Mr S attended a locum GP at his regular general practice for a driving assessment test. During the consultation, the GP advised Mr Smith that he had assessed him as eligible to have his licence renewed. Being from interstate, however, and unfamiliar with the form, the locum GP had unwittingly ticked an incorrect box which indicated, mistakenly, that he was assessed as *unsuitable* for the renewal of his licence.

When Mr Smith contacted the general practice explaining that the locum had incorrectly completed the form, he was instructed to attend the practice once again to undertake the same assessment. He was advised that he would be required to pay $80.00 for another assessment and the practice refused to negotiate about this. Clearly, it was not Mr Smith's fault that the form had been completed incorrectly. The OHCC resolved the complaint by contacting the locum GP, who was by then in Queensland. The GP was more than happy to amend the form and email it back to Mr Smith who was then able to submit the form to Service Tasmania and obtain his medium rigid licence.

Refusal by Pharmacy to Dispense Ritalin

Mr Q's GP obtained authority from the Pharmaceutical Services Board to prescribe the controlled drug Ritalin for him. When he took his prescription to a pharmacy, however, he was told that it could not dispense the medication for him. Due to his mental health issues, he was unable to liaise with his GP about this situation.

This Office contacted Mr Q's general practice which made some enquiries and learnt that the pharmacist in question was not able to see on a database that the prescribing GP was an approved Ritalin prescriber, and had neglected to call Mr Q's General Practice to check if it was a mistake. The practice manager contacted the pharmacy and advised of the mistake and Mr Q's medication was promptly dispensed.

Cases Closed in Assessment

No Post-operative Care Instructions

Discharged from hospital following surgery with no care plan, Mr K experienced an adverse reaction and presented to the Emergency Department. He was advised that what he was experiencing was entirely normal in his circumstances. Mr K complained it should be a matter of routine procedure that information be provided to all patients on discharge to prevent any unnecessary return to hospital, which is neither good for the patient or a very over stretched public health system.

Our Office contacted the Nurse Unit Manager (NUM) who apologised to Mr K unreservedly. The NUM acknowledged that there had been a failure to provide post-operative care information to Mr K. The NUM advised that the hospital had recently received some funding to create information packs for patients, and these would be provided in the future.

Improvement in Post Hospital Discharge Care at the Prison

A prison inmate complained that the Correctional Primary Health Service (CPHS) had failed to manage his post-operative care appropriately. He claimed that he had suffered an excessive amount of pain and that he had been mistakenly released back into the general prison population following his discharge when he should have been admitted to the CPHS in-patients clinic.

The CPHS disputed the inmate's claim that his care had been inadequate and submitted evidence to support its claim that the inmate had received appropriate care and pain management from the service whilst an outpatient. It agreed with the inmate, however, that he should have been able to see a list of medications in his discharge summary from the hospital so that he could better understand why he received the medications that he did.

Because of this complaint, the CPHS introduced an obligation on all staff to provide patients with adequate information about their management plans following discharge from hospital.

Consultation with AHPRA about a Dispensing Error

A consumer complained that a pharmacist had dispensed to her the incorrect dose of her prescribed medication and that she subsequently became unwell and required medical treatment.

AHPRA was consulted and the Pharmacy Board of Australia determined to investigate the dispensing pharmacist. The Board cautioned the pharmacist involved for not appropriately supervising medication dispensed by her assistant.

Additionally, our Office identified that pharmacy staff had failed to follow their own internal dispensing policies and procedures and these departures were raised with the pharmacy. Recommendations were made regarding the importance of staff training and the monitoring of compliance with their organisation's policies and procedures.

Communication Concerns during a Birth

Dismayed by the standard of care and treatment they received from a public hospital during, and immediately following the birth of their baby, who suffered from cystic fibrosis, the parents complained to the OHCC.

The OHCC sought responses from the Hospital to the parent's main issues of concern, namely that:

- medical practitioners failed to consult with them about deviating from their birth plan;
- physiotherapy treatment had been provided to the baby without obtaining consent; and
- their suggestions and recommendations to the cystic fibrosis team at the hospital were largely dismissed.

Following consultation with the OHCC, the Hospital agreed there were areas where there could be for improvement and the following outcomes were achieved:

- the format of birthing plans has been adapted to allow for patient and midwife sign-off;
- consent will now be obtained from parents before commencing physiotherapy treatment on babies, and that consent should be documented; and
- information will be provided to interested families about placing items on the agenda at annual planning days held by the cystic fibrosis team.

Risks of Emailing Confidential Patient Information

A member of the public complained to the OHCC that he was erroneously receiving emails intended for staff of a private medical practice. These emails contained confidential patient information. Despite advising the medical practice of the situation, he continued to receive the emails.

The OHCC contacted the practice's management which agreed to ensure all staff were made aware of this problem. To ensure patient confidentiality we made the following suggestions to the practice, namely that it:

- request Primary Health Tasmania to circulate the correct practice email address;
- recognise that the use by health professionals of standard unencrypted emails containing confidential patient information in a manner which is neither safe nor secure and which does not adequately protect the patient's privacy, may breach the Australian Privacy Principles;
- be cognisant of the relevant guidelines provided by the Royal Australian College of General Practitioners about privacy; and
- raise concerns with the senders of unencrypted emails containing confidential patient information and make arrangements with them to reduce the risk of breaching patient privacy.

The Importance of Taking Complaints Seriously

Mrs M considered she had been treated unprofessionally during a consultation with her GP. She consequently wrote a letter to the practice manager (PM) expressing her concerns but received no response. Mrs M then complained to our Office about both the standard of care she had received from the GP and the lack of response from the practice.

Attempts to manage the complaint through our early resolution process proved unsuccessful and the matter was escalated. A response was sought from the GP and AHPRA was consulted. Mrs M received an apology from the GP and chose not to take the matter further.

Our Office provided information to the practice manager about the importance of having a comprehensive policy for dealing with complaints. Failure to acknowledge and respond quickly, in the spirit of resolution, indicates that the complaint is not being taken seriously and tends to exacerbate the original grievance.

Functional Assessments Prior to Discharge From the Emergency Department

An older person presented at an Emergency Department with a leg injury. At the time of discharge from the ED, the patient was unable to walk or weight bear. A few days later she experienced a fall and subsequently required costly respite care. The complainant believed the fall would have been avoided had she been admitted to hospital initially. Resolution was achieved by the hospital reimbursing the cost of the respite care. OHCC recommended that ED staff seek assistance from rehabilitation services to assess a patient's suitability to return to their home, and whether they will require further rehabilitation services or respite prior to discharging that patient. The hospital has implemented this recommendation.

Informed Financial Consent

The complainant received a quote over the phone from a dental clinic for a check-up. He was later charged three times the quoted amount for additional services rendered without the opportunity to provide informed financial consent. OHCC facilitated the early resolution of the complaint resulting in the additional amount being refunded. The dental practice agreed to implement the OHCC recommendation that they remind dentists to discuss fees for dental work with patients and that they provide a notice about dental fees on their website including standard fees and noting that there may be additional costs.

Adverse Reaction to Medication

The complainant was taken by ambulance to a hospital emergency department. On the way she was administered pain medication to which she suffered an adverse reaction. The medication caused her to feel disoriented and, as she left the hospital, she fell. She later found she had a broken rib. She attempted to address her concerns with the hospital and then contacted OHCC for assistance. The complaint was resolved with the payment of compensation and an undertaking from the hospital to review its processes regarding medication reactions and to improve its discharge process and signage at the hospital.

Case Closed Following Conciliation

Staining from iron infusion

The complainant underwent a post-operative iron infusion. She had complained of pain from the outset, but had been reassured that this was normal and the infusion had continued. The nurse involved later identified that the cannula had 'tissued' and the infusion had leaked into the surrounding tissue. The infusion was stopped but resulted in permanent staining and ongoing tenderness and discomfort.

The initial response from the hospital was that the actions of the nurse involved had been in keeping with their policy. They had however reviewed and updated the policy to improve the reporting and awareness of clinical observations in the care of intravenous access devices.

The Nursing and Midwifery Board of Australia expressed the view that the cannula should have been removed at the first report of pain in accordance with the instructions on the 'Iron Infusion Polymaltose & Carboxymaltose – Procedure and Order Chart'.

The complaint was referred to conciliation where a financial settlement was negotiated.

Cases Closed Following Investigation

Investigation into Older Person's Mental Health Unit

An investigation was conducted into a complaint made by a woman on behalf of her deceased father about his admission to an older person's mental health unit (the Unit)

During the father's admission, he suffered a fall and was admitted to hospital with a fracture. He was provided with palliative care and passed away. The coroner recommended that the Unit undertake a review of its processes surrounding the risk of falls.

The investigation focused on whether or not the Unit had sufficiently reviewed its processes as well as the standard of care provided to the father at the time.

The investigation found that the Unit had made significant inroads into improving the care provided to its patients. There had been an influx of new staff, it had achieved full accreditation, staff had access to ongoing and comprehensive training and a number of positive initiatives had been implemented.

Recommendations were made in relation to the ongoing auditing of the Unit's medical records and the implementation of structured daily physical programs for patients. It was also recommended that new patients and their families and carers be provided with comprehensive information about the unit on admission, and that there be regular contact with families and carers, particularly if an incident occurs.

This Office will monitor the implementation of the recommendations.

Appendix 1 – Statistics

Table 5 - Reasons for Closure in Assessment Stage

Reason	2016-17	2017-18
Dismiss - Section 25 (5) (a) Complainant not a person entitled under s22	2	7
Dismiss - Section 25 (5) (b) Complaint does not disclose a subject matter referred to in s23	1	6
Dismiss - Section 25 (5) (c) Complainant became aware of the circumstance more than 2 years ago	4	1
Dismiss - Section 25 (5) (d) Complainant has not attempted direct resolution	5	9
Dismiss - Section 25 (5) (e) Issues adjudicated by court or tribunal	2	2
Dismiss - Section 25 (5) (g) Complainant has been given reasonable explanation and information	196	164
Dismiss - Section 25 (5) (h) The complaint lacks substance	3	4
Dismiss - Section 25 (5) (i)	2	0
Dismiss - Section 25 (5) (j) Complaint has been resolved	95	65
Dismiss - Section 25 (7) Complainant has failed to provide information under s24	0	3
Other	8	4
Out of Jurisdiction	4	5
Section 25 (1) (a) Complaint referred to the Ombudsman or another person	5	17
Section 30 (1) The complaint has been withdrawn in writing	2	3
Total	**329**	**290**

Outcomes achieved through the assessment process included apologies, provision of services, refunds of costs, and recommendations for (and the implementation of) quality improvements such as changes in policy or procedure as set out in Table 6. It should be noted that more than one outcome may result from one complaint. Examples of cases finalised in assessment appear in the case studies earlier in this report and are published on our website.

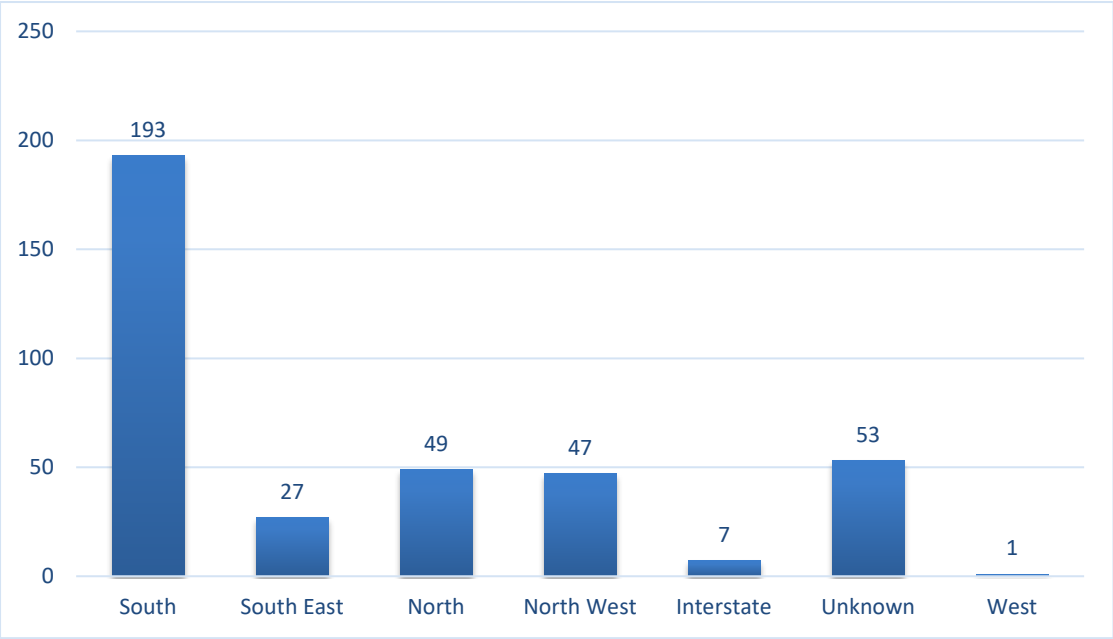
Table 6 - Outcomes from Assessment

Outcomes	**2016-17**	**2017-18**
Apology Given	43	25
Change in Policy	4	7
Change in Procedure	11	5
Compensation Received	1	3
Concern Registered	59	61
Explanation Given	243	169
Fees/Costs - Refunded, waived or reduced	9	10
Information obtained	41	80
Quality Improvement	25	16
Service Obtained	68	59
Total	**504**	**435**

Table 7 - Outcomes from Conciliation

Outcomes	**2016-17**	**2017-18**
Apology Given	17	4
Compensation Received	6	1
Concern Registered	9	2
Explanation Given	20	5
Information obtained	3	2
Quality Improvement	7	4
Service Obtained	0	1
Total	**62**	**19**

Figure 5 - Geographical location of complainants



What did they complain about?

A breakdown of the issues arising from complaints closed in the reporting year is set out in Tables 8 to 20. It should be noted that a significant number of complaints contain more than one issue.

Issues by category

Table 8 - Access Issues

Issue	2016-17	2017-18
Access to facility	1	0
Access to subsidies	0	1
Refusal to admit or treat	34	31
Service availability	18	9
Waiting lists	23	5
Total	**76**	**46**

Table 9 - Communication and Information Issues

Issue	2016-17	2017-18
Attitude / Manner	44	38
Inadequate information provided	28	27
Incorrect / misleading information provided	17	17
Special needs not accommodated	3	2
Total	**92**	**84**

Table 10 – Consent Issues

Issue	2016-17	2017-18
Consent not obtained or inadequate	10	4
Involuntary admission or treatment	2	2
Uninformed consent	2	1
Total	**14**	**7**

Table 11 – Discharge and Transfer Arrangements

Issue	2016-17	2017-18
Delay	1	3
Inadequate discharge	6	1
Mode of transport	0	3
Patient not reviewed	1	1
Total	**8**	**8**

Table 12 – Environment / Management of Facilities Issues

Issue	2016-17	2017-18
Administrative processes	1	7
Cleanliness/hygiene of facility	2	6
Physical environment of facility	5	7
Staffing and rostering	2	4
Statutory obligations/accreditation standards not met	2	1
Total	**12**	**25**

Table 13 – Fees and Costs

Issue	2016-17	2017-18
Billing Practices	17	12
Cost of treatment	4	6
Financial consent	9	5
Total	**30**	**23**

Table 14 – Grievance Processes

Issue	2016-17	2017-18
Inadequate / no response to complaint	11	18
Information about complaints procedures	0	1
Reprisal / retaliation as a result of complaint lodged	1	2
Total	**12**	**21**

Table 15 – Inquiry Service Issues

Issue	2016-17	2017-18
Request for information – Health Service	1	3

Issue	2016-17	2017-18
Request for information - Other	1	1
Request for Information - Commission	0	1
Request for information – Complaint mechanisms	0	3
Total	**2**	**8**

Table 16 – Medical Records

Issue	2016-17	2017-18
Access to/transfer of records	9	7
Record keeping	2	0
Records management	2	1
Total	**13**	**8**

Table 17 – Medication Issues

Issue	2016-17	2017-18
Administering medication	13	6
Dispensing medication	10	5
Prescribing medication	42	62
Supply/security/storage of medication	1	2
Total	**66**	**75**

Table 18 - OOJH Referred

Issue	2016-17	2017-18
Not specified	0	4
Total	**0**	**4**

Table 19 – Professional Conduct

Issue	2016-17	2017-18
Annual declaration not completed	1	0
Assault	4	0
Boundary violation	3	2
Competence	21	17
Discriminatory conduct	1	0
Emergency treatment not provided	0	1
Financial fraud	1	1
Illegal practice	2	0
Impairment	0	1
Inappropriate disclosure of information	6	4
Misrepresentation of qualifications	0	1
Sexual misconduct	0	2
Total	**39**	**29**

Table 20 – Reports / Certificates

Issue	2016-17	2017-18
Accuracy of report/certificate	2	3
Refusal to provide report/certificate	0	4
Report written with inadequate or no consultation	1	0
Total	**3**	**7**

Table 21 – Treatment Issues

Issue	2016-17	2017-18
Coordination of treatment	4	11

Issue	2016-17	2017-18
Delay in treatment	51	33
Diagnosis	26	12
Excessive treatment	1	1
Inadequate care	56	56
Inadequate consultation	3	6
Inadequate prosthetic equipment	4	5
Inadequate treatment	52	41
Infection control	3	1
No/inappropriate referral	3	7
Public/Private election	1	0
Rough and painful treatment	5	3
Unexpected treatment outcome/complications	34	22
Withdrawal of treatment	14	9
Wrong/inappropriate treatment	19	9
Total	**276**	**216**

Grand Total of Issues	**643**	**561**

Who did they complain about?

Table 22 – Complaints received about Health Organisations

Health Organisation	2016-17	2017-18
Aged Care	3	2
Ambulance	1	3
Community Health	1	3
Correctional Health	141	120
Dental	4	4
Dept of Health & Human Services	4	6
Diagnostic Services	3	0
Disability Services	0	3
Medical Practices/Clinics	31	27
Mental Health	6	9
Optometrist	0	1
Oral Health Services	2	2
Other	4	9
Pathology	2	1
Pharmacy/Pharmaceutical	5	5
Private Hospitals	16	14
Public Hospitals	51	75
Total	**274**	**284**

Hospitals

Table 23 – Issues Relating to Private Hospitals

Issue	2016-17	2017-18
Access	1	1
Communication & Information	3	5
Consent	1	0
Discharge and Transfer Arrangements	0	2
Environment/Management of Facilities	2	2
Fees & Costs	1	6
Grievance Processes	5	1
Professional Conduct	2	2
Treatment	11	12
Total	**26**	**31**

Table 24 – Issues Relating to Public Hospitals

Issue	2016-17	2017-18
Access	10	10
Communication & Information	29	34
Consent	8	3
Discharge & Transfer Arrangements	6	4
Environment/Management of Facilities	8	5
Fees and Costs	2	0
Grievance Processes	4	9
Medication	7	8
Professional Conduct	8	5

Issue	2016-17	2017-18
Reports/Certificates	1	0
Treatment	85	70
Total	**168**	**148**

Individual Providers

Table 25 - Complaints to HCC about Individual Providers

Provider	2016-17	2017-18
Dental	6	7
Exempt	0	1
Medical Practitioner	52	71
Nurse	1	0
Optometrist	2	1
Other/Unknown	1	12
Pharmacist	2	0
Physiotherapist	0	1
Total	**64**	**93**